



OFFICE OF THE ATTORNEY GENERAL

AUTHORIZATION FOR RELEASE AND DISCLOSURE OF HEALTH INFORMATION

(This form has been approved by the New York State Department of Health)

Patient Name:	Date of Birth:	Social Security Number:
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I, _____, hereby authorize the below-named individual or organization to disclose and release the above-named patient's health information, as described below, to the Attorney General of the State of New York, or to any Assistant Attorney General, or _____ for the purpose of litigation.

THE TYPE AND AMOUNT OF INFORMATION TO BE USED OR DISCLOSED IS AS FOLLOWS:

The complete medical record/chart of the above-named patient and all health information including, but not limited to, all medical records, hospital records, physicians' records, surgeons' records, consultation records, operative reports, physical therapy and other therapy records; x-ray, CT scan, MRI, PET scan and reports or other diagnostic studies; laboratory reports; patient information and history questionnaire; physicals and history; discharge summary; progress notes; prescriptions and medication records; nurses' notes; correspondence; consent for treatment; statements for services rendered; or any other materials (whether written or stored, created or maintained in any other form) relating or pertaining to this patient, including documents and records received from or that were created by another provider. All records, writings, or other information provided shall bear the certification or authentication of the physician releasing the information or of the head of the hospital, laboratory, department or bureau of the municipal corporation that is releasing the information, or of an employee delegated for that purpose.

I understand that the information in the patient's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), the virus that causes AIDS. I understand that confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV infection, HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV. I understand that the information released or disclosed pursuant to this authorization may be subject to redisclosure by the recipient if the recipient is not a health care provider or health plan covered by law. Such redisclosure is restricted or limited by NYS Public Health Law Article 27-F. The information released or disclosed pursuant to this authorization may also include information about behavioral or mental health services, or treatment for alcohol or drug abuse.

This authorization shall remain in full force and effect until it expires five years from the date set forth below, unless otherwise stated.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing by sending or presenting my written revocation to the Privacy Contact of the health care provider named. I understand that the revocation of this authorization will not apply to the extent that the health care provider has taken action in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage, or if another law provides the insurer with the right to contest a claim under the policy or the policy itself.

I understand that authorizing the disclosure of this health care information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure of the patient's health information by the recipient, resulting in the health information no longer being protected by Federal or State confidentiality rules.

The name and address of the health care provider authorized to release and disclose the requested health information is:

DATED: _____

(Signature and, if appropriate, legal relationship to patient)

A COPY OF THIS AUTHORIZATION MAY BE ACCEPTED WITH THE SAME FORCE AND EFFECT AS THE ORIGINAL.